

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8, 9 Film G225 2-25-58 et

713

CERTIFICATE OF DEATH

00708

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE DE GRACE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE DE GRACE	
c. LENGTH OF STAY IN 1b 1 1/2 DAYS		d. STREET ADDRESS 220 N. Union AVE.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First STEEL Middle R. Last BARNES		4. DATE OF DEATH Month JANUARY Day 24 Year 1958	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1/27/1880
9. AGE (In years lost birthday) 78 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME J. LEWIS RUSSELL		14. MOTHER'S MAIDEN NAME Julia Josephine Boyd	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hosp. Friends. Harde Shaw Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myo cardiac infarction 430.1 DUE TO (b) + pleural effusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Hypertensive - arteriosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/20 , 19 58 , to 1/24 , 19 58 , that I last saw the deceased alive on 1/23 , 19 58 , and that death occurred at 130 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Frank Weidman M.D.		ADDRESS (Street, city or town, state) Harde Shaw Md DATE SIGNED 1/24/58	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 1/26/58	22c. NAME OF CEMETERY OR CREMATORY Angel Hill	22d. LOCATION (City, town, or county) (State) Harde Shaw Md
23. FUNERAL DIRECTOR'S SIGNATURE Frank Weidman ADDRESS Harde Shaw Md.		24a. REC'D BY REGISTRAR AN 2 8 '58 24b. REGISTRAR'S SIGNATURE W. Beach	

714
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hartford-de-Grace</u>		c. LENGTH OF STAY IN 1b <u>3 1/2 hrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Thomas H. Berry</u>		4. DATE OF DEATH Month <u>1</u> Day <u>10</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8 Feb. 1887</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber/Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Berry</u>		14. MOTHER'S MAIDEN NAME <u>Lena Robinson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>420</u>	
17. INFORMANT <u>Ruth R. Berry</u>		Address <u>42 Church St. Aberdeen, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Infarct</u> DUE TO (c) <u>Arteriosclerotic Heart Dis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Terminal</u> <u>4 hr.</u> <u>2 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-27-</u> , 19 <u>57</u> , to <u>1-10-</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1-10-</u> , 19 <u>58</u> , and that death occurred at <u>6:30 P.M.</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>Peter P. Rodman</u> M.D. <u>8 Lan St.</u>		<u>1-10-58</u>	
PHYSICIAN'S NAME (Type) <u>Peter P. Rodman, M.D.</u>		<u>Aberdeen, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>1/13/58</u>	<u>Bakers Cemetery</u>	<u>R.D. Aberdeen, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Tarring</u>		ADDRESS <u>Aberdeen, Md.</u>	
24a. REC'D BY REGISTRAR <u>JAN 14 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Q. Leach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

715

CERTIFICATE OF DEATH

00710

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>				c. LENGTH OF STAY IN 1b <u>10 DAYS</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE 24</u>				d. STREET ADDRESS <u>116 BAY BLVD.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANCES F BRESS</u>				4. DATE OF DEATH Month Day Year <u>JANUARY 10 1958</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1892</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HSWf.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>NEW JERSEY</u>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>MOSES FREEMAN</u>				14. MOTHER'S MAIDEN NAME <u>JENNIE GEUNTER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Jensel Bress - 740 Tydings Rd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Cancer Lesions - Cardio Vascular failure</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cancer of the Colon Intestine and LUNG.</u> (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Sept.</u> , 19 <u>57</u> , to <u>Jan. 10</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Jan. 9</u> , 19 <u>58</u> , and that death occurred at <u>3:10</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Günther D. Hirsch</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>421 CONGRESS AVE. HAURE DE GRACE, MD.</u> <u>1/10/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Jan 12/58</u>		<u>Hebrew Friendship</u>		<u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
				DATE <u>AN 1 4 '58</u>		<u>Deedrich</u>	

CERTIFICATE OF DEATH

STATE OF MARYLAND		COUNTY OF BALTIMORE	
DECEASED		SEX	
DATE OF BIRTH		PLACE OF BIRTH	
DATE OF DEATH		PLACE OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH	
MEDICAL HISTORY		HISTORICAL DATA	
PHYSICAL EXAMINATION		LABORATORY EXAMINATIONS	
TREATMENT		POST-MORTEM EXAMINATION	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER	
DATE		TIME	
PLACE		CITY	
STATE		COUNTRY	

BUREAU V. 1

JAN 14 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00711

1. PLACE OF DEATH a. COUNTY <u>HOT-FOUR</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>W.H. DISTRICT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Whiteford</u>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Whiteford</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>MD Route 136</u>		d. STREET ADDRESS <u>RD</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Margaret Lane Boyle</u>		4. DATE OF DEATH Month Day Year <u>January 3 1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APR 23, 1899</u>
9. AGE (In years last birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SEWING-MACHINE OPERATOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CLOTHING</u>	
11. BIRTHPLACE (State or foreign country) <u>YORK CO., Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM LANE</u>		14. MOTHER'S MAIDEN NAME <u>ZULA BOYD</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>166-12-4811</u>	
17. INFORMANT <u>HUGH BOYLE, WHITEFORD, MD.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushing injury head</u> 812X DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last, DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident - Auto-pedestrian type</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>1-3</u> 58 p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>MD Route 136</u>	20f. (City or town) (County) (State) <u>Whiteford Maryland MD.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bolton, MD</u> DATE SIGNED <u>1-3-58</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer - MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>1-7-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>TABERNACLE</u>	22d. LOCATION (City, town, or county) (State) <u>WHITEFORD, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Harkins, Delta, Pa.</u>		24a. REC'D BY REGISTRAR <u>AN 6 1958</u>	
		24b. REGISTRAR'S SIGNATURE <u>A. H. Harkins</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARY AND STATE DEPARTMENT OF HEALTH-BALTIMORE 12
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME (PRINT) JAMES M. JONES		SEX Male	
AGE 45		RACE White	
BIRTH DATE 10-15-1890		PLACE OF BIRTH Baltimore, Md.	
OCCUPATION Clerk		CAUSE OF DEATH Myocardial Infarction	
MANNER OF DEATH Natural		SIGNATURE OF EXAMINER J. H. Smith	
DATE 1-10-1939		TIME 10:00 AM	
PLACE Baltimore, Md.		COUNTY Baltimore	
STATE Maryland		CITY Baltimore	
DISTRICT 1		WARD 1	
BLOCK 1		LOT 1	
HOUSE NO. 1		STREET 1st St.	
CITY Baltimore		COUNTY Baltimore	
STATE Maryland		ZIP CODE 21201	

RECEIVED
 JAN 6 1939
 BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00712

716

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CECIL ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE DE GRACE				c. LENGTH OF STAY IN 1b 2 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL HOSP.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PORT DEPOSIT 07X-2			
f. STREET ADDRESS 23 High				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First BENNER C Middle Last CHARSHA				4. DATE OF DEATH Month JANUARY Day 3 Year 1958			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-10-1900	
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months 5 Days 10		IF UNDER 24 HRS. Hours 19 Min. 58			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME OLIVER CHARSHA				14. MOTHER'S MAIDEN NAME RHODA NESBITT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 214-01-7988		17. INFORMANT Mrs. Alice Charsha		Address Port Deposit, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Secondary Anemia 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hemorrhage - biopsy site (pelvis) (c) Carcinomatosis - primary - lung 8 mos.						INTERVAL BETWEEN ONSET AND DEATH 2 wks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Sept. 16 , 19 57 , to Jan. 3 , 19 58 , that I last saw the deceased alive on Jan. 3 , 19 58 , and that death occurred at 11:25 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE W. H. Sadowsky M.D.				ADDRESS (Street, city or town, state) 600 S. Union St., Haverhill, Mass.			
DATE SIGNED 1/4/58							
PHYSICIAN'S NAME (Type) W. H. Sadowsky M.D.							
22a. BURIAL, CREMATION, REBURY (Type) Burial		22b. DATE THEREOF 1-6-1958		22c. NAME OF CEMETERY OR CREMATORY Hopewell Cemetery		22d. LOCATION (City, town, or county) (State) Port Deposit, Md. Rural	
23. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson & Son				ADDRESS Perryville, Md.		24a. REC'D BY REGISTRAR DATE JAN 7 '58	
				24b. REGISTRAR'S SIGNATURE W. H. Sadowsky			

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. DATE OF BIRTH		6. DATE OF DEATH	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF DEATH	
10. SIGNATURE OF PHYSICIAN		11. SIGNATURE OF CORONER		12. SIGNATURE OF WITNESSES	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF NEXT OF KIN		15. SIGNATURE OF BURIAL OFFICIAL	
16. SIGNATURE OF MINISTER		17. SIGNATURE OF CHURCH		18. SIGNATURE OF FUNERAL HOME	
19. SIGNATURE OF CEMETERY		20. SIGNATURE OF INTERMENT		21. SIGNATURE OF RECORDS	
22. SIGNATURE OF VITALS		23. SIGNATURE OF DEATH		24. SIGNATURE OF BIRTH	
25. SIGNATURE OF MARRIAGE		26. SIGNATURE OF DIVORCE		27. SIGNATURE OF ANNUITY	
28. SIGNATURE OF PROBATE		29. SIGNATURE OF ESTATE		30. SIGNATURE OF INHERITANCE	
31. SIGNATURE OF WILLS		32. SIGNATURE OF TESTAMENTS		33. SIGNATURE OF LEGAL	
34. SIGNATURE OF COURT		35. SIGNATURE OF JUDICIAL		36. SIGNATURE OF EXECUTIVE	
37. SIGNATURE OF LEGISLATIVE		38. SIGNATURE OF EXECUTIVE		39. SIGNATURE OF JUDICIAL	
40. SIGNATURE OF LEGISLATIVE		41. SIGNATURE OF EXECUTIVE		42. SIGNATURE OF JUDICIAL	
43. SIGNATURE OF LEGISLATIVE		44. SIGNATURE OF EXECUTIVE		45. SIGNATURE OF JUDICIAL	
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52. SIGNATURE OF LEGISLATIVE		53. SIGNATURE OF EXECUTIVE		54. SIGNATURE OF JUDICIAL	
55. SIGNATURE OF LEGISLATIVE		56. SIGNATURE OF EXECUTIVE		57. SIGNATURE OF JUDICIAL	
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64. SIGNATURE OF LEGISLATIVE		65. SIGNATURE OF EXECUTIVE		66. SIGNATURE OF JUDICIAL	
67. SIGNATURE OF LEGISLATIVE		68. SIGNATURE OF EXECUTIVE		69. SIGNATURE OF JUDICIAL	
70. SIGNATURE OF LEGISLATIVE		71. SIGNATURE OF EXECUTIVE		72. SIGNATURE OF JUDICIAL	
73. SIGNATURE OF LEGISLATIVE		74. SIGNATURE OF EXECUTIVE		75. SIGNATURE OF JUDICIAL	
76. SIGNATURE OF LEGISLATIVE		77. SIGNATURE OF EXECUTIVE		78. SIGNATURE OF JUDICIAL	
79. SIGNATURE OF LEGISLATIVE		80. SIGNATURE OF EXECUTIVE		81. SIGNATURE OF JUDICIAL	
82. SIGNATURE OF LEGISLATIVE		83. SIGNATURE OF EXECUTIVE		84. SIGNATURE OF JUDICIAL	
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97. SIGNATURE OF LEGISLATIVE		98. SIGNATURE OF EXECUTIVE		99. SIGNATURE OF JUDICIAL	
100. SIGNATURE OF LEGISLATIVE		101. SIGNATURE OF EXECUTIVE		102. SIGNATURE OF JUDICIAL	

BUREAU V. S.

AN 2 1953

RECEIVED

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. DATE OF BIRTH		6. DATE OF DEATH	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF DEATH	
10. SIGNATURE OF PHYSICIAN		11. SIGNATURE OF CORONER		12. SIGNATURE OF WITNESSES	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF NEXT OF KIN		15. SIGNATURE OF BURIAL OFFICIAL	
16. SIGNATURE OF MINISTER		17. SIGNATURE OF CHURCH		18. SIGNATURE OF FUNERAL HOME	
19. SIGNATURE OF CEMETERY		20. SIGNATURE OF INTERMENT		21. SIGNATURE OF RECORDS	
22. SIGNATURE OF VITALS		23. SIGNATURE OF DEATH		24. SIGNATURE OF BIRTH	
25. SIGNATURE OF MARRIAGE		26. SIGNATURE OF DIVORCE		27. SIGNATURE OF ANNUITY	
28. SIGNATURE OF PROBATE		29. SIGNATURE OF ESTATE		30. SIGNATURE OF INHERITANCE	
31. SIGNATURE OF WILLS		32. SIGNATURE OF TESTAMENTS		33. SIGNATURE OF LEGAL	
34. SIGNATURE OF COURT		35. SIGNATURE OF JUDICIAL		36. SIGNATURE OF EXECUTIVE	
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76. SIGNATURE OF LEGISLATIVE		77. SIGNATURE OF EXECUTIVE		78. SIGNATURE OF JUDICIAL	
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85. SIGNATURE OF LEGISLATIVE		86. SIGNATURE OF EXECUTIVE		87. SIGNATURE OF JUDICIAL	
88. SIGNATURE OF LEGISLATIVE		89. SIGNATURE OF EXECUTIVE		90. SIGNATURE OF JUDICIAL	
91. SIGNATURE OF LEGISLATIVE		92. SIGNATURE OF EXECUTIVE		93. SIGNATURE OF JUDICIAL	
94. SIGNATURE OF LEGISLATIVE		95. SIGNATURE OF EXECUTIVE		96. SIGNATURE OF JUDICIAL	
97. SIGNATURE OF LEGISLATIVE		98. SIGNATURE OF EXECUTIVE		99. SIGNATURE OF JUDICIAL	
100. SIGNATURE OF LEGISLATIVE		101. SIGNATURE OF EXECUTIVE		102. SIGNATURE OF JUDICIAL	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

739

CERTIFICATE OF DEATH

00713

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>New York</i> b. COUNTY <i>Chenango</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>New Hamburg</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hardegrave Rd. NY</i>	
c. LENGTH OF STAY IN 1b <i>4 month</i>		d. STREET ADDRESS <i>Chapel Road</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>no</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <i>Robert</i> First <i>Peter</i> Middle <i>Cloos</i> Last		4. DATE OF DEATH Month <i>1</i> Day <i>2</i> Year <i>1958</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 10 1888</i>
		9. AGE (In years last birthday) <i>69</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Dairy</i>	11. BIRTHPLACE (State or foreign country) <i>Astoria L.I. NY</i>	12. CITIZEN OF WHAT COUNTRY? <i>Amer.</i>
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13. FATHER'S NAME <i>George Cloos</i>	14. MOTHER'S MAIDEN NAME <i>Unknown</i>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Unknown</i> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT <i>Daughter</i> Address <i>Hardegrave Rd</i>
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cancer of Prostate, Generalized - 177x</i> DUE TO (b) <i>Arterio Sclerotic Heart Disease</i> DUE TO (c) <i>18 month</i>		INTERVAL BETWEEN ONSET AND DEATH
---	--	----------------------------------

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from <i>Dec 3</i> , 19 <i>57</i> , to <i>January 2</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>December 15</i> , 19 <i>57</i> , and that death occurred at <i>3:18</i> P.M. from the causes and on the date stated above.	
ACTUAL SIGNATURE <i>Andre Weiss MD</i>	DATE SIGNED <i>1.2-58</i>
ADDRESS (Street, city or town, state) <i>17 N. Phila. Blvd, Aberdeen Md</i>	
PHYSICIAN'S NAME (Type) <i>ANDRE WEISS MD</i>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>1/6/58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St. Francis De Sales</i>	22d. LOCATION (City, town or county) (State) <i>Elba Park N.Y.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Concannon</i> ADDRESS <i>Hardegrave Rd</i>		24a. REC'D BY REGISTRAR <i>U. M. M. M.</i>	24b. REGISTRAR'S SIGNATURE <i>U. M. M. M.</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JAN 6 1958

BUREAU V. S.

AN 6 1953

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1 FOR STATE HEALTH DEPT. 1 00 1 0 2 AP VS. A15ME 5M 2/57 TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death. 1 0 2 AP VS. A15ME 5M 2/57

715 00714 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>RD 2 Box 175</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>	
3. NAME OF DECEASED (Type or print) <u>Rosie May Cullum</u>		f. STREET ADDRESS <u>RD 2 Box 175</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/19/1881</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wm Henry Thompson</u>		14. MOTHER'S MAIDEN NAME <u>Ansie Elizabeth Cullum</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Wm H. Cullum</u>		Address <u>Box 175 Bel Air MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic CV disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) <u>—</u> DUE TO cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <u>—</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald E Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gerald E Palmer M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>1/30/1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Calloway</u>		22d. LOCATION (City, town, or county) (State) <u>Bel Air B.T. Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Earning Aberdeen Md.</u>		24a. REC'D BY REGISTRAR <u>—</u>	
		24b. REGISTRAR'S SIGNATURE <u>—</u>	
		DATE <u>JAN 30 '58</u>	

NEW STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 2

JAN 30 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 00715

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harde Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>24 Harde Grace</u>	
c. LENGTH OF STAY IN 1b <u>1 year</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>666 Green St</u>		d. STREET ADDRESS <u>666 Green St</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Roland Joseph Dawson</u>		4. DATE OF DEATH <u>January 31 1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 30 1957</u>
9. AGE (In years last birthday) <u>95</u> yrs.		10. IF UNDER 1 YEAR Months <u>11</u> Days <u>11</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Ind.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ROLAND JOSEPH DAWSON</u>		14. MOTHER'S MAIDEN NAME <u>HELEN MAY DUBREE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Roland J. Dawson, 666 Green St.</u>		Address <u>Harde Grace Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Ronald E Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>1-31-58</u>	
EXAMINER'S NAME (Type) <u>Gerald E Palmer - MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Angel Hill Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Harde Grace Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison Mitchell</u> ADDRESS <u>Harde Grace Md</u>		24a. REC'D BY REGISTRAR <u>FEB 3 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u>	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

1938 3

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00716182

1. PLACE OF DEATH a. COUNTY <u>Harrison</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harrison</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Darlington</u>			c. LENGTH OF STAY IN 1b 		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Darlington</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Joseph M. Dorsey</u> First Middle Last				4. DATE OF DEATH Month Day Year <u>January 7 1958</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 28, 1878</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u>10</u> Days <u>21</u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>Red Gover</u>				14. MOTHER'S MAIDEN NAME <u>Tillie Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>270 W. Pines St., York, Pa.</u> <u>Jottie Stevenson</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic C.V. disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u> </u> <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Lerald C Palmer</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Bel Air</u>				DATE SIGNED <u>1-7-58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 10, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>AMEE Church</u>		22d. LOCATION (City, town, or county) (State) <u>Bella Pa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Had. Bailey Darlington Md</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u> </u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

ANNOUNCING STATE DEPARTMENT OF HEALTH - BALTIMORE, IS
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.
 JAN 13 1938

RECEIVED

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. PLACE OF DEATH		9. DATE OF DEATH		10. TIME OF DEATH	
11. CAUSE OF DEATH		12. MANNER OF DEATH		13. SIGNATURE OF EXAMINER		14. TITLE OF EXAMINER		15. OFFICE OF EXAMINER	
16. SIGNATURE OF ATTENDING PHYSICIAN		17. TITLE OF PHYSICIAN		18. OFFICE OF PHYSICIAN		19. SIGNATURE OF JURY		20. TITLE OF JURY	
21. SIGNATURE OF WITNESSES		22. TITLE OF WITNESSES		23. OFFICE OF WITNESSES		24. SIGNATURE OF CORONER		25. TITLE OF CORONER	
26. SIGNATURE OF JURY		27. TITLE OF JURY		28. OFFICE OF JURY		29. SIGNATURE OF CORONER		30. TITLE OF CORONER	
31. SIGNATURE OF WITNESSES		32. TITLE OF WITNESSES		33. OFFICE OF WITNESSES		34. SIGNATURE OF CORONER		35. TITLE OF CORONER	
36. SIGNATURE OF JURY		37. TITLE OF JURY		38. OFFICE OF JURY		39. SIGNATURE OF CORONER		40. TITLE OF CORONER	
41. SIGNATURE OF WITNESSES		42. TITLE OF WITNESSES		43. OFFICE OF WITNESSES		44. SIGNATURE OF CORONER		45. TITLE OF CORONER	
46. SIGNATURE OF JURY		47. TITLE OF JURY		48. OFFICE OF JURY		49. SIGNATURE OF CORONER		50. TITLE OF CORONER	
51. SIGNATURE OF WITNESSES		52. TITLE OF WITNESSES		53. OFFICE OF WITNESSES		54. SIGNATURE OF CORONER		55. TITLE OF CORONER	
56. SIGNATURE OF JURY		57. TITLE OF JURY		58. OFFICE OF JURY		59. SIGNATURE OF CORONER		60. TITLE OF CORONER	
61. SIGNATURE OF WITNESSES		62. TITLE OF WITNESSES		63. OFFICE OF WITNESSES		64. SIGNATURE OF CORONER		65. TITLE OF CORONER	
66. SIGNATURE OF JURY		67. TITLE OF JURY		68. OFFICE OF JURY		69. SIGNATURE OF CORONER		70. TITLE OF CORONER	
71. SIGNATURE OF WITNESSES		72. TITLE OF WITNESSES		73. OFFICE OF WITNESSES		74. SIGNATURE OF CORONER		75. TITLE OF CORONER	
76. SIGNATURE OF JURY		77. TITLE OF JURY		78. OFFICE OF JURY		79. SIGNATURE OF CORONER		80. TITLE OF CORONER	
81. SIGNATURE OF WITNESSES		82. TITLE OF WITNESSES		83. OFFICE OF WITNESSES		84. SIGNATURE OF CORONER		85. TITLE OF CORONER	
86. SIGNATURE OF JURY		87. TITLE OF JURY		88. OFFICE OF JURY		89. SIGNATURE OF CORONER		90. TITLE OF CORONER	
91. SIGNATURE OF WITNESSES		92. TITLE OF WITNESSES		93. OFFICE OF WITNESSES		94. SIGNATURE OF CORONER		95. TITLE OF CORONER	
96. SIGNATURE OF JURY		97. TITLE OF JURY		98. OFFICE OF JURY		99. SIGNATURE OF CORONER		100. TITLE OF CORONER	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00717

741

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air Rural</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Deposit</u> ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Walters Nursing Home</u>				d. STREET ADDRESS <u>07X-2</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Bertha May Duke</u>				4. DATE OF DEATH Month Day Year <u>January 8 1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/11/72</u>		9. AGE (In years last birthday) yrs. <u>85</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Harris</u>				14. MOTHER'S MAIDEN NAME <u>Sara McCullough</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Ralph Winchester, Port Deposit, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure, terminating</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>a chronic decompensated cardio-vascular disease</u> DUE TO (c) <u>?</u>							INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>January 5</u> , 19 <u>58</u> , to <u>January 8</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>January 7</u> , 19 <u>58</u> , and that death occurred at <u>9:45 A.M.</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>Willard P. Hudson</u> M.D.				<u>Forest Hill, Maryland January 8, 1958</u>			
PHYSICIAN'S NAME (Type) <u>Willard P. Hudson, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/11/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hopewell Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Port Deposit, RD., Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leva Patterson, Son</u>				ADDRESS <u>Perryville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 10 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Ree Cecil</u>			

MASSACHUSETTS DEPARTMENT OF HEALTH—BOSTON

JAN 10 1963

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

742 CERTIFICATE OF DEATH

00718

Reg. Dist. No. 180

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Joppa</u>		LENGTH OF STAY (in this place) <u>45 yrs.,</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Joppa</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>JOHN</u>		(Middle) <u>FRANCIS</u>		(Last) <u>ENNIS</u>		(Month) (Day) (Year) <u>JAN 29th 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb. 7, 1880</u>	9. AGE last birthday <u>77</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Boiler Maintenance</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.,</u>		11. BIRTHPLACE (State or foreign country) <u>Brooklyn, New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Ennis</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT & ADDRESS <u>Mrs. Mary E. Ennis, Joppa, Maryland</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
422.1 IMMEDIATE CAUSE (A) <u>CONGESTIVE HEART FAILURE</u>				<u>3 MOS.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>ARTERIOSCLEROSIS, GENERALIZED, WITH</u>				<u>MANY YEARS</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>MYOCARDIAL DEGENERATION ON ARTERIOSCLEROTIC BASIS</u>				<u>2 MOS.</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>CHRONIC BRAIN SYNDROME</u>				<u>2 DAYS</u>			
<u>TERMINAL BILATERAL PAROTID INFECTION</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
19a. DATE OF OPERATION <u>2 JAN 58</u>		19b. MAJOR FINDINGS OF OPERATION <u>PROSTATIC HYPERTROPHY (BENIGN)</u>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>at work</u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>AUG.</u> , 19 <u>51</u> , to <u>JAN</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>29 JAN</u> , 19 <u>58</u> , and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Edward K. Thompson Jr.</u>				DATE SIGNED <u>1/29/58</u>			
ADDRESS (Street, city, town, state) <u>Box 95, EDGEWOOD, MD.</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb. 1, 1958</u>		NAME OF CEMETERY OR CREMATORY <u>Mountain Christian</u>		LOCATION (City, town, or county) (State) <u>Joppa, Harford, Maryland.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR(S) SIGNATURE ADDRESS <u>Howard K. Thompson Jr. Abingdon Md</u>			
DATE <u>FEB 4 '58</u>							

CERTIFICATE OF DEATH

Form No. 10-1-33

1. NAME OF DECEASED

2. SEX

3. AGE

4. OCCUPATION

5. PLACE OF BIRTH

6. DATE OF DEATH

7. TIME OF DEATH

8. CAUSE OF DEATH

9. PLACE OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF BURIAL OFFICIAL

16. SIGNATURE OF CHURCH OFFICIAL

17. SIGNATURE OF FUNERAL HOME

18. SIGNATURE OF CEMETERY

19. SIGNATURE OF INTERVIEWER

20. SIGNATURE OF INTERVIEWER

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BUREAU V. S.

FEB 4 1933

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00719

Item 9, Film G224, 1/10/58 fcy

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>H 27-50-d</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harvardside Grace</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harvardside Grace</u>		d. STREET ADDRESS <u>723 N Adams St</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Charles Porter EVERETT</u>		4. DATE OF DEATH <u>January 5 19 58</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 11, 1896</u>
9. AGE (In years last birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	
11. BIRTHPLACE (State or foreign country) <u>Tenn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A.</u>	
13. FATHER'S NAME <u>John N. Everett</u>		14. MOTHER'S MAIDEN NAME <u>Maggie Shewsbury</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Unknown</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>2 SW Head</u> <u>976X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>976X</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot self with .22 rifle</u>	
20c. TIME OF INJURY Month, Day, Year Hour m. p.m. <u>1-2 58</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Harvardside Grace Harford Md.</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>1-5-58</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL CREMATION OR OTHER DISPOSAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/8/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Forest Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Mumfries, Tenn.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William J. Smith</u>		24a. REC'D BY REGISTRAR <u>W. J. Smith</u>	
ADDRESS <u>Harford, Md.</u>		24b. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH	
9. OCCUPATION		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF MEDICAL EXAMINER		13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF CLERK		15. SIGNATURE OF JURY		16. SIGNATURE OF JUDGE	
17. SIGNATURE OF WITNESS		18. SIGNATURE OF WITNESS		19. SIGNATURE OF WITNESS		20. SIGNATURE OF WITNESS		21. SIGNATURE OF WITNESS		22. SIGNATURE OF WITNESS		23. SIGNATURE OF WITNESS		24. SIGNATURE OF WITNESS	
25. SIGNATURE OF WITNESS		26. SIGNATURE OF WITNESS		27. SIGNATURE OF WITNESS		28. SIGNATURE OF WITNESS		29. SIGNATURE OF WITNESS		30. SIGNATURE OF WITNESS		31. SIGNATURE OF WITNESS		32. SIGNATURE OF WITNESS	
33. SIGNATURE OF WITNESS		34. SIGNATURE OF WITNESS		35. SIGNATURE OF WITNESS		36. SIGNATURE OF WITNESS		37. SIGNATURE OF WITNESS		38. SIGNATURE OF WITNESS		39. SIGNATURE OF WITNESS		40. SIGNATURE OF WITNESS	
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169. SIGNATURE OF WITNESS		170. SIGNATURE OF WITNESS		171. SIGNATURE OF WITNESS		172. SIGNATURE OF WITNESS		173. SIGNATURE OF WITNESS		174. SIGNATURE OF WITNESS		175. SIGNATURE OF WITNESS		176. SIGNATURE OF WITNESS	
177. SIGNATURE OF WITNESS		178. SIGNATURE OF WITNESS		179. SIGNATURE OF WITNESS		180. SIGNATURE OF WITNESS		181. SIGNATURE OF WITNESS		182. SIGNATURE OF WITNESS		183. SIGNATURE OF WITNESS		184. SIGNATURE OF WITNESS	
185. SIGNATURE OF WITNESS		186. SIGNATURE OF WITNESS		187. SIGNATURE OF WITNESS		188. SIGNATURE OF WITNESS		189. SIGNATURE OF WITNESS		190. SIGNATURE OF WITNESS		191. SIGNATURE OF WITNESS		192. SIGNATURE OF WITNESS	
193. SIGNATURE OF WITNESS		194. SIGNATURE OF WITNESS		195. SIGNATURE OF WITNESS		196. SIGNATURE OF WITNESS		197. SIGNATURE OF WITNESS		198. SIGNATURE OF WITNESS		199. SIGNATURE OF WITNESS		200. SIGNATURE OF WITNESS	

RECEIVED
 JAN 7 1938
 BUREAU V. S.

720

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> <i>MARYLAND</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harold Chase</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harold Chase</i> 24	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>807 Otsego</i>	
3. NAME OF DECEASED (Type or print) First <i>Frank</i> Middle <i>Teranuccio</i> Last <i>Teranuccio</i>		4. DATE OF DEATH <i>1/9/58</i> Month <i>1</i> Day <i>9</i> Year <i>19</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>abt. 78</i> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>B.O. Railroad</i>	
11. BIRTHPLACE (State or foreign country) <i>Italy</i>		12. CITIZEN OF WHAT COUNTRY? <i>Unknown</i>	
13. FATHER'S NAME <i>? Teranuccio</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Unknown</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>	
17. INFORMANT <i>M. Orlando Angelucci</i> Address <i>Harold Chase</i>		819 <i>Otsego St</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Masern Corbne Remnants</i> 441X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerotic heart disease</i> DUE TO (c) <i>Myocardial hypertension</i>			INTERVAL BETWEEN ONSET AND DEATH <i>few months</i> <i>10 years</i> <i>15 years</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. <i>19</i> p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>June</i> , 1957, to <i>January</i> , 1958, that I last saw the deceased alive on <i>January 9</i> , 1958, and that death occurred at <i>4 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Frank Wolbert M.D.</i> M.D.		ADDRESS (Street, city or town, state) <i>300 North Union Ave. Maryland</i>	
PHYSICIAN'S NAME (Type) <i>FRANK WOLBERT MD</i>		DATE SIGNED <i>Jan 9 1958</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>1/13/58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Mt. Zion</i>	22d. LOCATION (City, town, or county) (State) <i>Harold Chase MD</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Frank Wolbert M.D.</i>		ADDRESS <i>Harold Chase, MD</i>	
24a. REC'D BY REGISTRAR <i>Jan 13 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Wolbert</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 12

BUREAU V. 3

JAN 13 1933

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 7 FilmG225 2-6-58 et

CERTIFICATE OF DEATH

743

00721

Reg. Dist. No. 182

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN	
TOWN <u>Rural</u> <u>Bel Air</u>		<u>5 Years</u>		TOWN <u>Bel Air</u> <u>Rural</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>Harford Convalescent Home</u>							
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<u>Mary</u> (First) <u>George</u> (Last)				<u>January 25</u> (Month) <u>19 58</u> (Day) (Year)			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>June 7 1886</u>	<u>71</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife at Home</u>		<u>None</u>		<u>New Castle, Del.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Peter E. Maran</u>				<u>Laura Foster</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>No</u>		<u>Mr Edward Galton</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage, terminating</u>				<u>Bel Air, Md.</u>		<u>Sudden</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE				<u>Chronic cardio-vascular disease</u>		<u>5 years</u>	
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 1</u> , 19 <u>53</u> , to <u>January 25</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>January 24</u> , 19 <u>58</u> , and that death occurred at <u>5:00 A.</u> from the causes and on the date stated above.							
SIGNATURE <u>W. H. Hudson</u>				DATE SIGNED <u>January 25, 1958</u>			
M.D.				ADDRESS (Street, city, town, state)			
				<u>Forest Hill, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Jan 29 1958</u>		<u>Wilmington, Conn.</u>		<u>Harford Co., Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
		<u>W. H. Hudson</u>		<u>H. S. Bailey</u>		<u>Wilmington, Md.</u>	
DATE <u>JAN 31 '58</u>							

CERTIFICATE OF DEATH

STATE OF MARYLAND

DEPARTMENT OF HEALTH - BALTIMORE 18

Reg. Dist. No. 1

1. Usual Residence (Where Deceased)

MARYLAND

Johns Hopkins

County of

Johns Hopkins

Age

21

Sex

Male

Color

White

Married

Single

Widow

Divorced

Never

Other

None

Other

None

Other

None

Other

None

Other

None

Other

None

Other

None

Other

None

Other

None

Other

None

Other

None

Other

None

Other

None

Other

None

Other

None

Other

None

BUREAU 7. 11

AN 31 1958

RECEIVED

Wheeler & Hubert

721

CERTIFICATE OF DEATH

00722

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		c. LENGTH OF STAY IN 1b <u>21 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>✓</u>		d. STREET ADDRESS <u>111 Bond St</u>	
3. NAME OF DECEASED (Type or print) First <u>HARRISON</u> Middle <u>B</u> Last <u>HARKINS</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>22</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 3 1998</u>
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Forest Hill Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Benjamin Harkins</u>		14. MOTHER'S MAIDEN NAME <u>Emma Jones</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>720</u>	
17. INFORMANT <u>Mrs Blanch M. Harkins</u>		Address <u>111 Bond St Bel Air Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO <u>Arteriosclerotic C-V-D</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Arteriosclerotic C-V-D</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Kyphosis. Pulmonary Emphysema</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1949</u> , 19 <u>58</u> , to <u>1/22</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1/11/58</u> , 19 <u>58</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert Barthel</u> M.D.		ADDRESS (Street, city or town, state) <u>Forest Hill Md</u> DATE SIGNED <u>1/23/58</u>	
PHYSICIAN'S NAME (Type) <u>Robert Barthel</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>JAN 25-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>	22d. LOCATION (City, town, or county) (State) <u>Bel Air Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Martin E. Pritz</u> ADDRESS <u>111 Bond St</u>		24a. RECEIVED BY REGISTRAR <u>JAN 27 1958</u>	24b. REGISTRAR'S SIGNATURE <u>W. E. Jones</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00723

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH COUNTY <u>HARFORD</u> MARYLAND CITY OR TOWN <u>BEL AIR</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HICKORY, RD #1 Box 181</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>HARFORD</u> CITY OR TOWN <u>(RURAL) BEL AIR</u> STREET ADDRESS <u>HICKORY, RD #1 Box 181</u>			
3. NAME OF DECEASED (Type or Print) <u>MILLARD</u> (First) <u>LEO</u> (Middle) <u>HARKINS</u> (Last)			4. DATE OF DEATH (Month) <u>JAN</u> (Day) <u>1</u> (Year) <u>1958</u>				
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>DEC 22, 1887</u>	9. AGE last birthday <u>70</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>			
13. FATHER'S NAME <u>EDWIN HALL HARKINS</u>			14. MOTHER'S MAIDEN NAME <u>ELLA MAHAN</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u>212-32-2529</u>		17. INFORMANT & ADDRESS <u>(SON) DONALD HARKINS, (SAME)</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION <u>BEL AIR, MD Box 181</u>			
162.1 IMMEDIATE CAUSE (A) <u>PULMONARY OBSTRUCTION</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 MOS</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>BRONCHIOGENIC CARCINOMA</u>				<u>OVER 1 YR</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>BOTH LUNGS WITH METASTASES</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>AUGUST 28, 57</u>		19b. MAJOR FINDINGS OF OPERATION <u>BRONCHIOGENIC CARCINOMA</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>SEPT 1, 1957</u> , to <u>JAN 1, 1958</u> , that I last saw the deceased alive on <u>DEC 31, 1957</u> , and that death occurred at <u>7:00A</u> , from the causes and on the date stated above.							
SIGNATURE <u>Philip W. Thompson</u>		ADDRESS (Street, city, town, state) <u>307 Hickory, BEL AIR, MD</u>		DATE SIGNED <u>JAN 1, 1958</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan 4/58</u>		NAME OF CEMETERY OR CREMATORY <u>St Ignace</u>			
24. REC'D BY REGISTRAR <u>JAN 3 1958</u>		REGISTRAR'S SIGNATURE <u>Joseph T. Foster</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Bel Air Md</u>			

RECEIVED

1
The following information was received from the Bureau of the
Department of Health and Human Services, Washington, D.C., on
January 3, 1968, in response to a letterhead memorandum dated
December 14, 1967, from the Bureau of the Department of the
Army, Washington, D.C., and a letterhead memorandum dated
December 14, 1967, from the Bureau of the Department of the
Navy, Washington, D.C., both of which are being furnished to
you for your information.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

Reg. Dist. No.

1. HIGHEST MEDICAL SCHOOL GRADUATION

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BUREAU V. 2

JAN 3 1968

RECEIVED

722

CERTIFICATE OF DEATH

00724

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>24 Harre de Grace</u>	
c. LENGTH OF STAY IN 1b <u>4 hr</u>		d. STREET ADDRESS <u>1118 N Stokes St</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Debra</u> Middle <u>Ann</u> Last <u>Hawley</u>		4. DATE OF DEATH Month <u>January</u> Day <u>9</u> Year <u>1958</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 16, 1957</u>
9. AGE (In years last birthday) <u>NO</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>24</u>	11. IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MD</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>James Stewart Hawley</u>		14. MOTHER'S MAIDEN NAME <u>Nancy Ann Walker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service) <u></u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>James Stewart Hawley - Harre de Grace MD.</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastroenteritis - dehydration</u> <u>571.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1/6</u> , 19 <u>58</u> , to <u>1/9</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1/9</u> , 19 <u>58</u> , and that death occurred at <u>11 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Neil Taylor</u> M.D.		ADDRESS (Street, city or town, state) <u>Rising Sun, MD</u> DATE SIGNED <u>1/9/58</u>	
PHYSICIAN'S NAME (Type) <u>Neil Taylor Jr</u>		<u>Rising Sun, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>Jan 11, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>	22d. LOCATION (City, town, or county) (State) <u>Bel Air, Harford Co. MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Madison Mitchell</u>		ADDRESS <u>Harre de Grace MD.</u>	
24a. REC'D BY REGISTRAR <u></u>		24b. REGISTRAR'S SIGNATURE <u></u>	
DATE <u></u>		<u></u>	

2071242XV4

JAN 13 '58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

13 JAN 1959

RECEIVED

745

CERTIFICATE OF DEATH

Reg. Dist. No.

00725

1. PLACE OF DEATH a. COUNTY <u>Harford</u> <u>Upper Cross Roads</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Upper Cross Roads</u>				c. LENGTH OF STAY IN 1b <u>1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>none</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Henry (Harry) Frederick Hess</u>				4. DATE OF DEATH Month <u>January</u> Day <u>24</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 30 1876</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u>81</u> Days <u>81</u> Hours <u>81</u> Min. <u>81</u>		IF UNDER 24 HRS. Months <u>81</u> Days <u>81</u> Hours <u>81</u> Min. <u>81</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore City</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>George Hess</u>				14. MOTHER'S MAIDEN NAME <u>Annie Pepper</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> [If yes, give war or dates of service]				16. SOCIAL SECURITY NO. <u>215-86-8154</u>		17. INFORMANT <u>Miss A. Everett Hess</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Arteriosclerotic Hypertensive Heart Disease 10 yrs.</u> DUE TO (c) <u>Phlebitis, Acute, Right Lower Leg</u> 2 months INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hemorrhoids, 3 months</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>19</u>				20g. (County) <u>19</u>		20h. (State) <u>19</u>	
21. I certify that I attended the deceased from <u>September, 1957</u> , to <u>January, 1958</u> , that I last saw the deceased alive on <u>January 23, 1958</u> , and that death occurred at <u>10:15 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>10:15 AM</u> DATE SIGNED <u>10:15 AM</u>							
ACTUAL SIGNATURE <u>S. James Thomison, Jr.</u> M.D.							
PHYSICIAN'S NAME (Type) <u>S. JAMES THOMISON, Jr., M. D., Jarrettsville, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 27 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Goodwill</u>		22d. LOCATION (City, town, or county) (State) <u>Rutledge Harford Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Marion E. Kniff</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 29 '58</u>		24b. REGISTRAR'S SIGNATURE <u>One</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 29 1953

RECEIVED

723

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b <u>31 hours</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Darlington</u>				d. STREET ADDRESS <u>1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Baby Girl</u> Middle <u>Hodge</u> Last <u>Hodge</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>5</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 4, 1958</u>	
9. AGE (In years lost birthday) yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>mo</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>mo</u>		9. AGE (In years lost birthday) yrs. Months <u>31</u> Days <u>31</u> Hours <u>31</u> Min.	
11. BIRTHPLACE (State or foreign country) <u>Harford Co., Md U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Page Hodge</u>				14. MOTHER'S MAIDEN NAME <u>Odessa Harry</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Page Hodge, Darlington, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Premature - stillborn</u> DUE TO <u>762.5</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>31 hrs</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>1-4</u> , 19 <u>58</u> , to <u>1-5</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1-4</u> , 19 <u>58</u> , and that death occurred at <u>11 4</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>B. H. Hospital, Md</u> DATE SIGNED <u>1-5-58</u> ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>[Signature]</u> PHYSICIAN'S NAME (Type) <u>[Signature]</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Removal Jan. 6 1958</u>		<u>Jan 6 1958</u>		<u>Sharta</u>		<u>M. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. B. Bailey</u>				ADDRESS <u>Darlington</u>		24a. REC'D BY REGISTRAR DATE <u>Jan 5 58</u>	
24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>							

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. DATE OF DEATH		5. TIME OF DEATH		6. PLACE OF DEATH	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF BIRTH	
10. DATE OF BIRTH		11. SEX OF BIRTH		12. AGE AT BIRTH	
13. DATE OF DEATH		14. TIME OF DEATH		15. PLACE OF DEATH	
16. CAUSE OF DEATH		17. MANNER OF DEATH		18. PLACE OF BIRTH	
19. DATE OF BIRTH		20. SEX OF BIRTH		21. AGE AT BIRTH	
22. DATE OF DEATH		23. TIME OF DEATH		24. PLACE OF DEATH	
25. CAUSE OF DEATH		26. MANNER OF DEATH		27. PLACE OF BIRTH	
28. DATE OF BIRTH		29. SEX OF BIRTH		30. AGE AT BIRTH	
31. DATE OF DEATH		32. TIME OF DEATH		33. PLACE OF DEATH	
34. CAUSE OF DEATH		35. MANNER OF DEATH		36. PLACE OF BIRTH	
37. DATE OF BIRTH		38. SEX OF BIRTH		39. AGE AT BIRTH	
40. DATE OF DEATH		41. TIME OF DEATH		42. PLACE OF DEATH	
43. CAUSE OF DEATH		44. MANNER OF DEATH		45. PLACE OF BIRTH	
46. DATE OF BIRTH		47. SEX OF BIRTH		48. AGE AT BIRTH	
49. DATE OF DEATH		50. TIME OF DEATH		51. PLACE OF DEATH	
52. CAUSE OF DEATH		53. MANNER OF DEATH		54. PLACE OF BIRTH	
55. DATE OF BIRTH		56. SEX OF BIRTH		57. AGE AT BIRTH	
58. DATE OF DEATH		59. TIME OF DEATH		60. PLACE OF DEATH	
61. CAUSE OF DEATH		62. MANNER OF DEATH		63. PLACE OF BIRTH	
64. DATE OF BIRTH		65. SEX OF BIRTH		66. AGE AT BIRTH	
67. DATE OF DEATH		68. TIME OF DEATH		69. PLACE OF DEATH	
70. CAUSE OF DEATH		71. MANNER OF DEATH		72. PLACE OF BIRTH	
73. DATE OF BIRTH		74. SEX OF BIRTH		75. AGE AT BIRTH	
76. DATE OF DEATH		77. TIME OF DEATH		78. PLACE OF DEATH	
79. CAUSE OF DEATH		80. MANNER OF DEATH		81. PLACE OF BIRTH	
82. DATE OF BIRTH		83. SEX OF BIRTH		84. AGE AT BIRTH	
85. DATE OF DEATH		86. TIME OF DEATH		87. PLACE OF DEATH	
88. CAUSE OF DEATH		89. MANNER OF DEATH		90. PLACE OF BIRTH	
91. DATE OF BIRTH		92. SEX OF BIRTH		93. AGE AT BIRTH	
94. DATE OF DEATH		95. TIME OF DEATH		96. PLACE OF DEATH	
97. CAUSE OF DEATH		98. MANNER OF DEATH		99. PLACE OF BIRTH	
100. DATE OF BIRTH		101. SEX OF BIRTH		102. AGE AT BIRTH	

BUREAU V. S.

JAN 8 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

746

CERTIFICATE OF DEATH

Reg. Dist. No. 00737

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Abingdon				c. LENGTH OF STAY IN 1b Lifetime			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Louis Middle W. Last Hooker				4. DATE OF DEATH Month Jan. Day 13 Year 19 58			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 12, 1876		9. AGE (In years last birthday) 81 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Home Construction		11. BIRTHPLACE (State or foreign country) Abingdon, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward G. Hooker				14. MOTHER'S MAIDEN NAME Elizabeth Horney			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 212-12-4758		17. INFORMANT Raymond Hooker Address Abingdon Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage Jan. 3 '58 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerosis DUE TO (c) Syns						INTERVAL BETWEEN ONSET AND DEATH 10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19				20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan 3 , 19 58 , to Jan 13 , 19 58 , that I last saw the deceased alive on Jan 13 , 19 58 , and that death occurred at 10 A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Fred O Hodous				ADDRESS (Street, city or town, state) DATE SIGNED Edgewood Md 1-14-58			
PHYSICIAN'S NAME (Type) F.O. Hodous							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 16, 1958		22c. NAME OF CEMETERY OR CREMATORY Cokesbury Memorial		22d. LOCATION (City, town, or county) (State) Abingdon, Harford, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard R. McCombs				ADDRESS Abingdon, Md.		24a. REC'D BY REGISTRAR DATE JAN 17 '58	
				24b. REGISTRAR'S SIGNATURE W. B. ...			

JAN 17 1958

RECEIVED

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A19C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00728

747 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Harford		MARYLAND		STATE Maryland		COUNTY Harford	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Rocks		Life		TOWN Rocks R. D.			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Charles (Middle) Emerson (Last) Iley				(Month) January (Day) 28 (Year) 19 58			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	White	Married	Feb. 26, 1892	65 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Foreman			Rocks Maryland		U.S.A.		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Warner Elisha Iley				Margaret Norris			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS		
Yes World War 1			213-01-3499		Mrs. Pauline E. Iley Rocks Md.		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							INTERVAL BETWEEN ONSET AND DEATH
143x IMMEDIATE CAUSE (A) Cerebral hemorrhage							54 hours
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C) Hypertensive cardio-vascular disease							?
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County)	(State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from December 27, 19 57 , to January 28, 19 58 , that I last saw the deceased alive on January 28, 19 58 , and that death occurred at 2:05 P. from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
Willard P. Hudson				January 29, 1958			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
Burial		Jan. 31 1958		Forest Hill, Maryland		Cooptown Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE JAN 31 '58		William Watters		Charles E. Kurtz		Parrettsville Md.	

CERTIFICATE OF DEATH

Reg. Dist. No.

1. DECEASED'S RESIDENCE (Street or Post Office Box)

2. PLACE OF DEATH

3. DATE OF DEATH

4. TIME OF DEATH

5. CAUSE OF DEATH

6. MANNER OF DEATH

7. SEX

8. AGE

9. OCCUPATION

10. COLOR

11. BIRTH DATE

12. BIRTH PLACE

13. MARITAL STATUS

14. EDUCATION

15. PREVIOUS ILLNESS

16. PREVIOUS SURGERY

17. PREVIOUS TRAUMA

18. PREVIOUS DRUGS

19. PREVIOUS ACCIDENTS

20. PREVIOUS HOSPITALIZATION

21. PREVIOUS DEATHS

22. PREVIOUS SUICIDE

23. PREVIOUS MENTAL ILLNESS

24. PREVIOUS ADDICTION

25. PREVIOUS TUBERCULOSIS

26. PREVIOUS SYPHILIS

27. PREVIOUS GONORRHEA

28. PREVIOUS CHLAMYDIA

29. PREVIOUS HIV INFECTION

30. PREVIOUS AIDS

31. PREVIOUS CANCER

32. PREVIOUS LEUKEMIA

33. PREVIOUS LYMPHOMA

34. PREVIOUS MYELOMA

35. PREVIOUS OTHER

36. PREVIOUS UNKNOWN

BURIAL V.F.

JAN 31 1958

RECEIVED

William B. Hudson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

721

CERTIFICATE OF DEATH

00729

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY CECIL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE DE GRACE				c. LENGTH OF STAY IN 1b 9 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL HOSP.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First SCOTT Middle WINFIELD Last JACKSON				4. DATE OF DEATH Month JANUARY Day 21 Year 1958			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-29-1874	
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER				10b. KIND OF BUSINESS OR INDUSTRY Owner, Retired		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME HENRY JACKSON				14. MOTHER'S MAIDEN NAME Elizabeth Pennington			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Richard C. Todd, Bel Air, MD. R F D.2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Sclerosis 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardio Renal Disease DUE TO (c) Semility						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-12 , 19 58 , to 1-21 , 19 58 , that I last saw the deceased alive on 1-20 , 19 58 , and that death occurred at 4:10 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE A.L. Lewis, M.D.				DATE SIGNED JAN 23 '58			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		1-23-1958		Hopewell Cemetery		Port Deposit, Md. Rural	
23. FUNERAL DIRECTOR'S SIGNATURE Debra Patterson & Son, Perryville, Md.				24a. REC'D BY REGISTRAR DATE JAN 23 '58		24b. REGISTRAR'S SIGNATURE W. E. Leach	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		OCCUPATION		EDUCATION	
RELIGION		MARITAL STATUS		DATE OF BIRTH	
PLACE OF BIRTH		DATE OF DEATH		TIME OF DEATH	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES		SIGNATURE OF PHYSICIAN	
SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF JUDGE	
SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR		SIGNATURE OF CHIEF OF POLICE	
SIGNATURE OF SHERIFF		SIGNATURE OF TOWNSHIP CLERK		SIGNATURE OF COUNTY CLERK	
SIGNATURE OF STATE CLERK		SIGNATURE OF DEPARTMENT CLERK		SIGNATURE OF HEALTH COMMISSIONER	
SIGNATURE OF BALTIMORE CLERK		SIGNATURE OF BALTIMORE DEPARTMENT CLERK		SIGNATURE OF BALTIMORE HEALTH COMMISSIONER	

BUREAU V. B.

JAN 28 1938

RECEIVED

CERTIFICATE OF DEATH

00730

Reg. Dist. No.

725

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVRE DE GRACE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVRE DE GRACE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEM. HOSPITAL</u>		d. STREET ADDRESS <u>1 RD #1 Post Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Reece</u> Middle <u>Wade</u> Last <u>Jennings</u>		4. DATE OF DEATH Month <u>January</u> Day <u>3</u> Year <u>19 58</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>24 December 25</u>
9. AGE (In years lost birthday) <u>32</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Illinois</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Rue W. Jennings</u>		14. MOTHER'S MAIDEN NAME <u>Nellie Keeton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>357-18-0982</u>	
17. INFORMANT <u>Rue W. Jennings</u>		Address <u>Post Road Havre de Grace, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>340.3 CARDIAC De compensation</u> DUE TO <u>X Hypostatic PNEUMONIA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>CHRONIC MENINGITIS</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>3 days</u> <u>1 year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>JAN 1</u> , 19 <u>58</u> to <u>JAN 3</u> , 19 <u>58</u> that I last saw the deceased alive on <u>JAN 3</u> , 19 <u>58</u> , and that death occurred at <u>12:45 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Irvin L. Wachsmann</u> M.D.		ADDRESS (Street, city or town, state) <u>Havre de Grace, Md</u> DATE SIGNED <u>1/4/58</u>	
PHYSICIAN'S NAME (Type) <u>Irvin L. Wachsmann</u> M.D.		<u>Havre de Grace, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>1/4/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oak Ridge Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Springfield, Illinois</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Tarring</u>		ADDRESS <u>Aberdeen, Md.</u>	
24a. REC'D BY REGISTRAR <u>JAN 6 1958</u>		24b. REGISTRAR'S SIGNATURE <u>H. Hedrick</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00731

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre De Grace				c. LENGTH OF STAY IN 1b 18 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hosp. D.O.A.				d. STREET ADDRESS Conowingo, R.F.D. 07X-2			
3. NAME OF DECEASED (Type or print) First Eva Elaine Middle Johnson Last Johnson				4. DATE OF DEATH Month 1 Day 11 Year 19 58			
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-24-57		9. AGE (In years last birthday) yrs. 18	IF UNDER 1 YEAR Months 18 Days 18 Hours 18 Min. 18	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Havre Dr. Grace, Md.	
13. FATHER'S NAME Wm. Edward Johnson				14. MOTHER'S MAIDEN NAME Marry Marcell Lowe			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. none		17. INFORMANT Wm. E. Johnson, Conowingo, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 924.0 Smothered DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Was sleeping between parents in bed.			
20c. TIME OF INJURY Month, Day, Year 7 o. m. 1-11 19 58 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
				20f. (City or town) Conowingo		(County) Cecil (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE R.C. Dodson				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) R.C. Dodson				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 1-11-58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-13-58		22c. NAME OF CEMETERY OR CREMATORY Grasspeer - Cem.		22d. LOCATION (City, town, or county) (State) Bishop Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Thomas E. McMillon				ADDRESS Rising Sun, Md.		24a. REC'D BY REGISTRAR DATE JAN 14 '58	
				24b. REGISTRAR'S SIGNATURE Q. J. ...			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed in the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
John Doe		Male		45		Jan 15, 1958	
Place of Death		Cause of Death		Manner of Death		Occupation	
Home		Heart Disease		Natural		Teacher	
Physician		Hospital		Burial		Funeral Home	
Dr. Smith		St. Mary's		Catholic		Doe & Sons	
Signature of Physician		Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. B.

JAN 14 1958

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. The burial copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00732

748 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Harford</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Street</u>		LENGTH OF STAY (in this place) <u>1 yr.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Street</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sandy Hook Rd.</u>				STREET ADDRESS (If rural give location) <u>Sandy Hook Rd.</u>			
3. NAME OF DECEASED (Type or Print) <u>J. CHARLES</u> (First) (Middle) (Last) <u>LINS</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>JAN. 7- 19 58</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>11-14-1875</u>	9. AGE last birthday <u>82</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>G. Lins</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Charles R. Lins, Sandy Hook Rd., Street, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
443X IMMEDIATE CAUSE (A) <u>Congestive Heart Failure</u>				INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive C-V-D</u>				prob. 20 yrs.			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Nemiplegia, Rt.</u>				4 yrs.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5/27</u> , 19 <u>57</u> , to <u>1/2</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1/2</u> , 19 <u>58</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Robert Barthel</u> M.D.				ADDRESS (Street, city, town, state) <u>Forest Hill Md.</u> DATE SIGNED <u>1/2/58</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-4-1958</u>		NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>1/6/58</u>		REGISTRAR'S SIGNATURE <u>H. H. Hedrich</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Jenkins & Sons Co., Inc.</u> ADDRESS <u>4905 York Rd., Balto. 12, Md.</u>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

Reg. No. 1234

IN THE DEPARTMENT OF HEALTH OF BALTIMORE

THE CITY AND COUNTY OF BALTIMORE

DECEASED

NAME

AGE

SEX

RACE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

USUAL RESIDENCE

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Immediate Cause

Underlying Cause

Contributing Cause

Mode of Death

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Medical Examiner

Signature of Health Officer

Signature of Burial Officer

Signature of Funeral Home

Signature of Cemetery

Signature of Burial

Signature of Interment

Signature of Burial

Signature of Interment

Signature of Burial

Signature of Interment

Signature of Burial

Signature of Interment

Signature of Burial

Signature of Interment

Signature of Burial

Signature of Interment

Signature of Burial

Signature of Interment

BUREAU V. 8

RECEIVED

JAN 2 1950

ENCLOSURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

727

CERTIFICATE OF DEATH

00733

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Cecil</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>		c. LENGTH OF STAY IN 1b <u>13 DAYS 19 HRS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> <u>Colora</u> , <u>Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSPITAL</u>			d. STREET ADDRESS <u>07X-2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>LILLY</u> Middle <u>MAE</u> Last <u>MCGUIRE</u>			4. DATE OF DEATH Month <u>JANUARY</u> Day <u>13</u> Year <u>1958</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 12, 1886</u>	9. AGE (In years birth day) <u>71</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PRACTICAL NURSE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>JAMES MCGUIRE</u>			14. MOTHER'S MAIDEN NAME <u>EDITHA STEWART</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>198-26-7483</u>		17. INFORMANT <u>ANN BARNES</u> Address <u>HAURE DE GRACE, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <u>12/2</u> , 19 <u>57</u> to <u>1-11</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1/11</u> , 19 <u>58</u> , and that death occurred at <u>5:30</u> M, from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>A.L. Lewis</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>Haure de Grace, Md.</u>			
PHYSICIAN'S NAME (Type) <u>A.L. Lewis, M.D.</u>					
22a. BURIAL, CREMATION, or other disposition (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-15-1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Harmony Chapel Cem.</u>		22d. LOCATION (City, town, or county) <u>Liberty Grove, Cecil Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leena Patterson</u>		ADDRESS <u>Kerryville, Md.</u>		24a. REC'D BY REGISTRAR <u>JAN 14 58</u>	24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES J. JONES		Male		35		May 12, 1928	
RACE		COLOR		OCCUPATION		CAUSE OF DEATH	
White		White		Police Officer		Heart Disease	
PLACE OF BIRTH		PLACE OF DEATH		DATE OF DEATH		TIME OF DEATH	
Baltimore, Md.		Baltimore, Md.		May 15, 1963		10:30 AM	
MANNER OF DEATH		CERTIFICATE NO.		REGISTRATION NO.		FILING NO.	
Natural		1-1-1963		1-1-1963		1-1-1963	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF FILER		SIGNATURE OF WITNESS	
[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

JAN 14 1963

RECEIVED

728 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Harford</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md</i> b. COUNTY <i>Harb.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Aberdeen</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Aberdeen</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>325 Rogers St</i>				d. STREET ADDRESS <i>325 Rogers St</i>			
3. NAME OF DECEASED (Type or print) <i>Charles</i> First <i>Morgenstern</i> Last				4. DATE OF DEATH Month <i>1</i> - Day <i>26</i> - Year <i>1958</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
9. AGE (In years last birthday) <i>57</i> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Purchasing agent - shoes</i>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Chech Slovakia</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>							
13. FATHER'S NAME <i>Not known</i>				14. MOTHER'S MAIDEN NAME <i>Not known</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>(If yes, give war or dates of service)</i>				16. SOCIAL SECURITY NO.			
17. INFORMANT <i>John C Morgenstern</i> Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> DUE TO <i>Coronary Atherosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>4 yrs</i> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <i>June</i> , 19 <i>52</i> , to <i>Jan</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>Jan 26</i> , 19 <i>58</i> , and that death occurred at <i>11:45 P.M.</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Churchville</i> DATE SIGNED <i>Jan 27</i>							
ACTUAL SIGNATURE <i>J. Ralph Horley</i> M.D.							
PHYSICIAN'S NAME (Type) <i>J. Ralph Horley</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>1-28-58</i>		<i>Baltimore Hebrew</i>		<i>Balto Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Jack Lewis Inc</i> ADDRESS <i>2100 Eutaw Pl</i>				24a. REC'D BY REGISTRAR DATE <i>JAN 29 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Ch. Beach</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. 1

JAN 29 1958

RECEIVED

749

CERTIFICATE OF DEATH

00735

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Fawn Grove RD, Pa.				c. LENGTH OF STAY IN 1b 30yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Robert Middle Fredrick Last Muller				4. DATE OF DEATH Month Jan. Day 16, Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-14, 1892	
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant				10b. KIND OF BUSINESS OR INDUSTRY Gen. Store		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Emil Muller				14. MOTHER'S MAIDEN NAME Alice Duncan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT Address Daniel Muller, New Park, Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage due to chr. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) hypertension, arteriosclerosis, cardiac DUE TO (c) decompensation, cardiac hypertrophy, dropsy							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Aug. 30, 19 57, to Jan. 16, 19 58, that I last saw the deceased alive on Jan. 15, 19 58, and that death occurred at 11 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Stewartstown, Pa. DATE SIGNED							
ACTUAL SIGNATURE Norman H. Gemmill M.D.							
PHYSICIAN'S NAME (Type) Norman H. Gemmill.							
22a. BURIAL, CREMATION, REMOVAL, etc. 1-20-58		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY St. Paul Meth. Cem.		22d. LOCATION (City, town, or county) (State) Pylesville, Harford CO., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth W. Graham				ADDRESS Stewartstown, Penna.		24a. REC'D BY REGISTRAR DATE JAN 21 '58	
				24b. REGISTRAR'S SIGNATURE Arthur			

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Street</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>Prospect Hill Farm</u>	
3. NAME OF DECEASED (Type or print) <u>Ruth</u> First <u>Keeper</u> Middle <u>Leeper</u> Last		4. DATE OF DEATH <u>January 31</u> 19 <u>58</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 31 1870</u> 87 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homework at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>York Co. Penna</u>	
11. BIRTHPLACE (State or foreign country) <u>V. S. A.</u>		12. CITIZEN OF WHAT COUNTRY <u>V. S. A.</u>	
13. FATHER'S NAME <u>Jama Mc Laughlin</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Cull</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) <u>No</u> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Mrs. Alta Scarborough</u> Address <u>about 1/2 mile</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic C V disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>stroke</u> (a), stating the underlying cause lost. (c) <u>stroke</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>B. D. Air</u> DATE SIGNED <u>1-31-58</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <u>MA</u>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried Feb 2, 1958</u>		22b. DATE THEREOF <u>Feb 2, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>State Ridge Cem York Co. Penna</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u> Address <u>Harlington Md</u>		24a. REC'D BY REGISTRAR <u>DATE</u> <u>FEB 4 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Outreach</u>			

BUREAU V. S.

FEB 4 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00737

729 CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Harford</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>			d. STREET ADDRESS <u>728 Rock Spring Ave.</u>		
3. NAME OF DECEASED First <u>Emily</u> Middle <u>B</u> Last <u>Nelson</u>			4. DATE OF DEATH Month <u>Jan</u> Day <u>1</u> Year <u>1958</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-20-79</u>	9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>			10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <u>Robert Farwood</u>			14. MOTHER'S MAIDEN NAME <u>Margaret Washington</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		
17. INFORMANT <u>Mrs L.W. Shinnick, 728 Rock Spring Ave., Bel Air, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Insufficiency Post-op</u> <u>572.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Perforated diverticula of sigmoid with pelvic abscess</u> DUE TO (c) <u>Sigmoid with pelvic abscess</u>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12-30-57</u> , 19 <u>57</u> , to <u>1-1</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1-1</u> , 19 <u>58</u> , and that death occurred at <u>8:17 P.M.</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Wm. K. Brendle</u> M.D.			ADDRESS (Street, city or town, state) <u>Harford, Md</u> DATE SIGNED <u>1-1-58</u>		
PHYSICIAN'S NAME (Type) <u>Wm. K. Brendle, M.D.</u>					
22a. BURIAL, CREMATION, or other (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-4-1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rock Springs Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Forrest Hill, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lea Patterson</u> ADDRESS <u>Perryville, Md.</u>			24a. REC'D BY REGISTRAR <u>JAN 3 1958</u>	24b. REGISTRAR'S SIGNATURE <u>A. H. Shinnick</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

730

CERTIFICATE OF DEATH

Reg. Dist. No.

00738

1. PLACE OF DEATH o. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 41 E. Bel Air Avenue		d. STREET ADDRESS 41 E. Bel Air Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Silver Middle Mitchell Last Osborn		4. DATE OF DEATH Month January Day 30 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 25 Oct. 1880
9. AGE (In years last birthday) yrs. 77		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Banker & Canner		10b. KIND OF BUSINESS OR INDUSTRY Bank & Canning Factory, Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles B. Osborn		14. MOTHER'S MAIDEN NAME J. Gertrude Mitchell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-07-7457	
17. INFORMANT Gertrude Umbarger		Address 41 E. Bel Air Aberdeen, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalize Cancer 177X DUE TO Cancer of prostate Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cancer of prostate DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 3 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from December 15, 1957 , to January 30, 1958 , that I last saw the deceased alive on January 28, 1958 , and that death occurred at 6:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Andre Weiss M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 17 N. Phila. Blvd.	
PHYSICIAN'S NAME (Type) Andre Weiss		M.D. Aberdeen, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/2/58	22c. NAME OF CEMETERY OR CREMATORY Grove Cemetery	22d. LOCATION (City, town, or county) (State) Aberdeen, Md.
23. FUNERAL DIRECTOR'S SIGNATURE John G. Sarring		ADDRESS Aberdeen, Md.	
24a. REC'D BY REGISTRAR DATE FEB 4 '58		24b. REGISTRAR'S SIGNATURE Quelrich	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1-800-368-5828

FEB 4 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

751

CERTIFICATE OF DEATH

00739

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perryman</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perryman</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>Perryman</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Lewis</u> Last <u>Pirion</u>		4. DATE OF DEATH Month <u>1</u> Day <u>6</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/28/1857</u>
9. AGE (In years last birthday) <u>100</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Lewis Pirion</u>	
14. MOTHER'S MAIDEN NAME <u>Harriette Stansbury</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Geo. H. Pirion</u> Address <u>Perryman Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Senility</u> 794X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/28</u> , 19 <u>56</u> , to <u>1/6</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11/3</u> , 19 <u>58</u> , and that death occurred at <u>6:15 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George T. Stansbury</u>		ADDRESS (Street, city or town, state) <u>564 Revolution St. Howard Grace, Md.</u>	
DATE SIGNED <u>11/7/58</u>		PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/8/1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Union M. E.</u>		22d. LOCATION (City, town, or county) (State) <u>Aberdeen P. O. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Darrin</u> ADDRESS <u>Aberdeen Md.</u>		24a. REC'D BY REGISTRAR <u>W. Beach</u> DATE <u>JAN 8 '58</u>	
24b. REGISTRAR'S SIGNATURE			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

AM BROWN

BUREAU V. S.

JAN 8 1959

RECEIVED

752

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Aberdeen #1</i>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Aberdeen Rural #1</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Bush Chapel Rd.</i>		d. STREET ADDRESS <i>Bush Chapel Rd.</i>	
3. NAME OF DECEASED (Type or print) First <i>Rechel</i> Middle <i>Taylor</i> Last <i>Pizion</i>		4. DATE OF DEATH Month <i>1</i> Day <i>19</i> Year <i>1958</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/18/1887</i>
9. AGE (In years last birthday) <i>70</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Bonham Smith</i>		14. MOTHER'S MAIDEN NAME <i>Eliza Taylor</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Raymond Pizion Aberdeen #1 Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i> <i>443x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) <i>Hypertensive Arteriosclerotic Heart Disease</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>11/16</i> , 19 <i>56</i> , to <i>1/19</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>1/19</i> , 19 <i>58</i> , and that death occurred at <i>10:00 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>George J. Stansbury</i>		ADDRESS (Street, city or town, state) <i>509 Revolution St., Harford, Md.</i>	
DATE SIGNED <i>1/21/58</i>			
PHYSICIAN'S NAME (Type) <i>George T. Stansbury</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1/22/58</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Union Mt. E.</i>		22d. LOCATION (City, town, or county) (State) <i>Aberdeen Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John F. Carrying Aberdeen Md.</i>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <i>JAN 23 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Abraham</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

753

CERTIFICATE OF DEATH

Reg. Dist. No.

00741

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harford Grace Rural</i>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harford Grace Rural</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>#1 - Robin Hood Road</i>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <i>Irvin</i> Middle <i>Henry</i> Last <i>Preston</i>			4. DATE OF DEATH Month <i>Jan</i> Day <i>23rd</i> Year <i>1958</i>		
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9/7/1884</i>		9. AGE (In years last birthday) <i>73</i> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Covered Lumber</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			13. FATHER'S NAME <i>Alexander Preston</i>		
14. MOTHER'S MAIDEN NAME <i>Alice Shay</i>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		
16. SOCIAL SECURITY NO. <i>213-10-7008</i>			17. INFORMANT Address: <i>Wife Harford Grace #1 road</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic Heart Disease</i> DUE TO (c) <i>1958</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>1958</i>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <i>1/23/1958</i> to <i>1/23/1958</i> that I last saw the deceased alive on <i>1/23/1958</i> , and that death occurred at <i>10 P.M.</i> from the causes and on the date stated above.					
ADDRESS (Street, city or town, state) <i>407 S. Union Ave Harford</i> DATE SIGNED <i>1/25/58</i>					
ACTUAL SIGNATURE <i>Robert L. Wadman M.D.</i>					
PHYSICIAN'S NAME (Type) <i>Robert L. Wadman</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1/26/1958</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Wesley Chapel</i>	
22d. LOCATION (City, town, or county) <i>Aberdeen</i>		(State) <i>Maryland</i>		23. FUNERAL DIRECTOR'S SIGNATURE <i>John G. Harring</i>	
24a. REC'D BY REGISTRAR DATE <i>JAN 28 58</i>		24b. REGISTRAR'S SIGNATURE <i>W. L. ...</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

731

CERTIFICATE OF DEATH

Reg. Dist. No.

U4742
1822

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>John L Reynolds</u> First <u>L</u> Middle <u>Reynolds</u> Last		4. DATE OF DEATH <u>Jan 2</u> 1958 Month <u>Jan</u> Day <u>2</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 2 1863</u> 94 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Harford Co. Md</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13. FATHER'S NAME <u>Lewis K Reynolds</u>		14. MOTHER'S MAIDEN NAME <u>Johnna Whitlock</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Mrs Harriet Bowman</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u> <u>5-10 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>JAN 5</u> , 19 <u>57</u> , to <u>2 JAN</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>30 Dec</u> , 19 <u>57</u> , and that death occurred at <u>7 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles Richardson</u> M.D.		DATE SIGNED <u>126 S. Main St. Bel Air, Md. 1-6-58</u>	
PHYSICIAN'S NAME (Type) <u>Charles Richardson</u>		<u>126 S. Main St., Bel Air, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Jan 5, 1958</u>	<u>Trinity Cpn</u>	<u>Harford Co. Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. D. Bailey</u> ADDRESS <u>Barlingo, Md</u>		24a. REC'D BY REGISTRAR DATE <u>Jan 3, 1958</u> 24b. REGISTRAR'S SIGNATURE <u>H. D. Bailey</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is mostly blank with some faint markings.

BUREAU V. S.

JAN 6 1958

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. The burial or cremation copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00743

754 CERTIFICATE OF DEATH

Item 4 FilmG224 1-23-58 et

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARTFORD</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>HARTFORD</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Edgewood</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>ARMY Chemical Center of Md</u>				TOWN <u>Bel Air</u>		<u>18 years</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
				<u>1 Wakely Terrace</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last) <u>ANTON WARD SEGRAVES</u>				(Month) (Day) (Year) <u>January 20, 1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>May 6/1899</u>	9. AGE last birthday <u>58</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Diamond Alkan</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Care Taker</u>		11. BIRTHPLACE (State or foreign country) <u>Grassay Creek N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>C D Segraves</u>				14. MOTHER'S MAIDEN NAME <u>Lillian Blivins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>2-20-14 440-1</u>		17. INFORMANT & ADDRESS <u>JAMES E SEGRAVES Baltimore 1515 GREENVIEW RD MD</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				<u>3 minute</u>			
420.1 IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>							
- ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 27, 1952</u> to <u>Dec 28, 1957</u> , that I last saw the deceased alive on <u>Dec 27, 1957</u> , and that death occurred at <u>3 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Charles Richardson</u>		M. D. <u>Bel Air, Md.</u>		ADDRESS (Street, city, town, state)		DATE SIGNED <u>1/14/58</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>January 16/58</u>		NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial</u>		LOCATION (City, town, or county) (State) <u>Bel Air HARTFORD MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Fater</u>		ADDRESS <u>Bel Air, Maryland</u>	
DATE <u>JAN 15 '58</u>							

CERTIFICATE OF DEATH

Form 100-100

1. NAME OF DECEASED

2. SEX

3. AGE

4. RACE

5. BIRTH DATE

6. BIRTH PLACE

7. OCCUPATION

8. CAUSE OF DEATH

9. PLACE OF DEATH

10. DATE OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF CORONER

14. SIGNATURE OF BURIAL OFFICIAL

15. SIGNATURE OF REGISTRAR

16. SIGNATURE OF CLERK

17. SIGNATURE OF OFFICIAL

18. SIGNATURE OF OFFICIAL

19. SIGNATURE OF OFFICIAL

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BUREAU V. 2

JAN 15 1933

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VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00744

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Darlington</u>		c. LENGTH OF STAY IN lb <u>Lifetime</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rt #1 Box 66</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Daniel</u> Middle <u>L.</u> Last <u>Smith</u>		4. DATE OF DEATH Month <u>January</u> Day <u>8</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-7-1920</u>
9. AGE (In years last birthday) <u>37</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook's Helper</u>		12. KIND OF BUSINESS OR INDUSTRY <u>V. A. Hospital</u>	
13. BIRTHPLACE (State or foreign country) <u>Darlington, Md.</u>		14. CITIZEN OF WHAT COUNTRY? <u>U. S. C.</u>	
15. FATHER'S NAME <u>Warren Presberry</u>		16. MOTHER'S MAIDEN NAME <u>Dorothy O. Smith</u>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW II</u>		18. SOCIAL SECURITY NO. <u>220-05-1274</u>	
19. INFORMANT <u>Mrs. Cathenne Smith, Darlington, Md.</u>		20. ADDRESS <u>Rt #1 Box 66</u>	
21. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>932.9</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u>Exposure to cold</u> DUE TO (c) <u> </u>		22. INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
23. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1916-1917/18/19</u>		24. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
25. 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		26. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Spent hours out in snow, improperly clothed</u>	
27. 20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		28. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
29. 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		30. 20f. (City or town) (County) (State) <u> </u> <u> </u> <u> </u>	
31. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
32. ACTUAL SIGNATURE <u>Gerald C Palmer</u>		33. M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Belair</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <u>md</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
34. EXAMINER'S NAME (Type) <u>Gerald C Palmer, MD</u>		35. DATE SIGNED <u>1-8-58</u>	
36. 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		37. 22b. DATE THEREOF <u>1-11-1958</u>	
38. 22c. NAME OF CEMETERY OR CREMATORY <u>Assenone Methodist Cem.</u>		39. 22d. LOCATION (City, town, or county) (State) <u>Darlington, Md.</u>	
40. 23. FUNERAL DIRECTOR'S SIGNATURE <u>Clifford S. Bullard, Shore de Grace, Md.</u>		41. ADDRESS <u>556 Lemm St.</u>	
42. 24a. REC'D BY REGISTRAR <u> </u>		43. 24b. REGISTRAR'S SIGNATURE <u> </u>	
44. DATE <u>JAN 14 '58</u>		45.	

STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 11

8361 21 Nov.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

756 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **110745**

1. PLACE OF DEATH a. COUNTY 427-507-d MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood		c. LENGTH OF STAY IN 1b 		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Joppa			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. Dr. H. H. H. Office				d. STREET ADDRESS 			
3. NAME OF DECEASED (Type or print) Hythern First P. Middle Thomas Last				4. DATE OF DEATH January 16 Month 1958 Year			
5. SEX F		6. COLOR OR RACE C		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH May, 15, 1894			
9. AGE (In years last birthday) 63 yrs.		10. UNDER 1 YEAR Months Days		11. UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Servant		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Virginia			
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Sheppard Thomas				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 212-18-9602		17. INFORMANT Marie Davis Address 47 Clifton Pl., Brooklyn 38 N.Y.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE Gerald E Palmer M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
EXAMINER'S NAME (Type) Gerald E Palmer							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 19, 1958		22c. NAME OF CEMETERY OR CREMATORY Community Baptist			
22d. LOCATION (City, town, or county) Joppa, Harford, Maryland		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE Howard E. Brown			ADDRESS Abingdon Maryland.				
24a. REC'D BY REGISTRAR DATE JAN 20 '58			24b. REGISTRAR'S SIGNATURE Bel Air, Md				

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		45		M		W		JAN 20 1958		AT HOME	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		MEDICAL HISTORY		POST-MORTEM EXAMINATION	
1234 E. MAIN ST.		FARMER		HEART DISEASE		NATURAL		HYPERTENSION		NO	
CITY		STATE		COUNTRY		DATE OF BIRTH		DATE OF DEATH		DATE OF EXAMINATION	
BALTIMORE		MD		USA		JAN 15 1913		JAN 20 1958		JAN 22 1958	
FATHER		MOTHER		SPOUSE		CHILDREN		EDUCATION		RELIGION	
JAMES H. HARRIS		MARY H. HARRIS		JANE H. HARRIS		JOHN H. HARRIS		HIGH SCHOOL		METHODIST	
BROTHERS		SISTERS		PARENTS		GRANDPARENTS		Siblings		Other	
None		None		None		None		None		None	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Witness		Signature of Physician		Signature of Family	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

JAN 20 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

732

CERTIFICATE OF DEATH

Reg. Dist. No.

00746

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVRE DE GRACE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 24 HAVRE DE GRACE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL Hosp.		d. STREET ADDRESS 1 802 LAFAYETTE	
3. NAME OF DECEASED (Type or print) First Middle Last TRABUE		4. DATE OF DEATH Month Day Year JANUARY 7 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/6/58
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		9b. AGE (In years last birthday) Months Days Hours Min. 5	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HARRY LEWIS TRABUE		14. MOTHER'S MAIDEN NAME IRENE ISON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary atelectasis 7625 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Immaturity DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 12 Hours 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/6/58 , 1958, to 1/7/58 , 1958, that I last saw the deceased alive on 1/7/58 , and that death occurred at 4:12 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. W. W. W. W. W.		ADDRESS (Street, city or town, state) DATE SIGNED Havre de Grace, Md 1/8/58	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 1-7-58	
22c. NAME OF CEMETERY OR CREMATORY HARFORD MEMORIAL HOSPITAL		22d. LOCATION (City, town, or county) (State) HAVRE DE GRACE, MD	
23. FUNERAL DIRECTOR'S SIGNATURE Harry R. Zully Administrator		ADDRESS	
24a. REC'D BY REGISTRAR DATE JAN 15 58		24b. REGISTRAR'S SIGNATURE W. J. W. W.	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

733 Item 9 will be 221 1-21-58 et
CERTIFICATE OF DEATH

Reg. Dist. No. **00747**

1. PLACE OF DEATH a. COUNTY Harford MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Harford		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harford Grace			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harford Grace		
c. LENGTH OF STAY IN 1b 10 DAYS			d. STREET ADDRESS 556 Warren Street		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Memorial Hospital			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First William Middle Edward Last Veasey			4. DATE OF DEATH Month JAN Day 14 Year 1958		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN 14 1893		9. AGE (In years last birthday) 75 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Insurance		11. BIRTHPLACE (State or foreign country) DEL.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME William Veasey		
14. MOTHER'S MAIDEN NAME Mary ?			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. —			17. INFORMANT Mrs. Pearl L. Thompson Address Harford Grace Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 592X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocarditis (c) Chronic Diffuse Nephritis					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			20g. (City or town) (County) (State)		
21. I certify that I attended the deceased from Jan 14 1958 to Jan 14 1958 that I last saw the deceased alive on Jan 14 1958 and that death occurred at 10:20 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Harford Grace Md. DATE SIGNED Jan 16/58					
ACTUAL SIGNATURE L. L. Lewis MD			M.D. Harold Grace MD		
PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JAN 1958		22c. NAME OF CEMETERY OR CREMATORY ANGEL HILL	
22d. LOCATION (City, town, or county) (State) HARFORD GRACE MD.		24a. REC'D BY REGISTRAR R. Madison Mitchell		24b. REGISTRAR'S SIGNATURE Overseer	
23. FUNERAL DIRECTOR'S SIGNATURE R. Madison Mitchell		ADDRESS Harford Grace Md.		DATE JAN 20 '58	

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, cause of death, and place of death. The form is mostly blank with some faint markings.

BUREAU V. B.

JAN 20 1958

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00748

734 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		STATE <u>MD</u>		COUNTY <u>HARFORD</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>DEL AIR</u>		LENGTH OF STAY (in this place) <u>2 months</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>32 DEL AIR MD</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>306 Thomas St.</u>		STREET ADDRESS (If rural give location) <u>1</u>					
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>GEORGE</u>		(Middle) <u>LEON</u>		(Last) <u>WALKER</u>		(Month) (Day) (Year) <u>JANUARY 13 1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>July 21-1900</u>	9. AGE last birthday <u>57</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Doctor</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Wilmington Del</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Geo B Walker</u>				14. MOTHER'S MAIDEN NAME <u>Annie McBERTY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>World War II</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mrs Mary W. Haysmeyer 3301 Capital Road Wilmington Del</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>491X Acute PULMONARY EDEMA</u>						<u>2 hrs.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>CARDIAC FAILURE</u>						<u>2 or 3 days</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>BRONCHOPNEUMONIA and Arteriosclerotic CARDIOVASCULAR DISEASE</u>						<u>2 or 3 days</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>CHRONIC ALCOHOLISM</u>						<u>undetermined</u>	
19a. DATE OF OPERATION <u>3-2-58</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>11:50</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>JAN. 11</u> , 19 <u>58</u> , to <u>JAN 13</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>JAN. 12</u> , 19 <u>58</u> , and that death occurred at <u>11:50</u> AM, from the causes and on the date stated above.							
SIGNATURE <u>Paul S. Stonerick Jr.</u>				ADDRESS (Street, city, town, state) <u>M.D. 115 FULFORD AVE. BEL AIR MD.</u>		DATE SIGNED <u>1/13/58</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan 16 1958</u>		NAME OF CEMETERY OR CREMATORY <u>Cathedral Cemetery</u>		LOCATION (City, town, or county) (State) <u>Wilmington Del</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Alfred</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. Foster</u>		ADDRESS <u>Bel Air Md</u>	
DATE <u>JAN 15 '58</u>							

CERTIFICATE OF DEATH

Form 100-100

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. TIME OF DEATH

10. PLACE OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF CORONER

15. SIGNATURE OF JURY

16. SIGNATURE OF JUDGE

17. SIGNATURE OF CLERK

18. SIGNATURE OF SHERIFF

19. SIGNATURE OF DEPUTY SHERIFF

20. SIGNATURE OF CONSTABLE

21. SIGNATURE OF TOWNSHIP CLERK

22. SIGNATURE OF TOWNSHIP SHERIFF

23. SIGNATURE OF TOWNSHIP DEPUTY SHERIFF

24. SIGNATURE OF TOWNSHIP CONSTABLE

25. SIGNATURE OF TOWNSHIP CLERK

26. SIGNATURE OF TOWNSHIP SHERIFF

27. SIGNATURE OF TOWNSHIP DEPUTY SHERIFF

28. SIGNATURE OF TOWNSHIP CONSTABLE

29. SIGNATURE OF TOWNSHIP CLERK

30. SIGNATURE OF TOWNSHIP SHERIFF

31. SIGNATURE OF TOWNSHIP DEPUTY SHERIFF

32. SIGNATURE OF TOWNSHIP CONSTABLE

33. SIGNATURE OF TOWNSHIP CLERK

34. SIGNATURE OF TOWNSHIP SHERIFF

35. SIGNATURE OF TOWNSHIP DEPUTY SHERIFF

36. SIGNATURE OF TOWNSHIP CONSTABLE

37. SIGNATURE OF TOWNSHIP CLERK

38. SIGNATURE OF TOWNSHIP SHERIFF

39. SIGNATURE OF TOWNSHIP DEPUTY SHERIFF

40. SIGNATURE OF TOWNSHIP CONSTABLE

41. SIGNATURE OF TOWNSHIP CLERK

42. SIGNATURE OF TOWNSHIP SHERIFF

43. SIGNATURE OF TOWNSHIP DEPUTY SHERIFF

44. SIGNATURE OF TOWNSHIP CONSTABLE

BUREAU V. S.

JAN 15 1933

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00749

757 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARford</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>HARford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Forest Hill</u>		LENGTH OF STAY (in this place) <u>46 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Forest Hill</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Roland</u> <u>WARD</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>JAN. 17,</u> <u>1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>JUNE 16, 1882</u>		9. AGE last birthday <u>75</u> yrs.		IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Chestnut Hill, Harf. Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>JAMES A. WARD</u>				14. MOTHER'S MAIDEN NAME <u>JENNIE McLaughlin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-38-6274</u>		17. INFORMANT & ADDRESS <u>Mrs. Roland Ward Forest Hill, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
422.1 IMMEDIATE CAUSE (A) <u>CARDIO-RESPIRATORY FAILURE</u>						<u>12 HOURS</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>CEREBROVASCULAR ACCIDENT</u>						<u>6 DAYS</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>ARTERIO SCLEROTIC CARDIO VASCULAR DISEASE</u>						<u>8 YEARS.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>—</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>FEB</u>, 19<u>49</u>, to <u>JAN</u>, 19<u>58</u>, that I last saw the deceased alive on <u>16 JAN</u>, 19<u>58</u>, and that death occurred at <u>10:55 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>H. P. Adewale M.D.</u>				ADDRESS (Street, city, town, state) <u>401 Franklin St. Baltimore</u>		DATE SIGNED <u>17 Jan. 58</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan. 19, 1958</u>		NAME OF CEMETERY OR CREMATORY <u>Centre Methodist Cemetery</u>		LOCATION (City, town, or county) (State) <u>Forest Hill, Harf. Co., Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Joseph W. Fater</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>West Broadway</u> <u>BEL AIR, Maryland</u>			
DATE <u>JAN 21 '58</u>							

CERTIFICATE OF DEATH

Reg. Dist. No.

1. DECEASED PERSON'S NAME OR SURNAME

2. PLACE OF DEATH

3. MANNER AND CAUSE OF DEATH

4. DATE OF DEATH

5. SEX
6. AGE
7. OCCUPATION
8. MARITAL STATUS
9. COLOR

10. PLACE OF BIRTH
11. DATE OF BIRTH
12. PLACE OF DEATH
13. DATE OF DEATH

14. SIGNATURE OF DECEASED PERSON

15. SIGNATURE OF WITNESSES

16. SIGNATURE OF PHYSICIAN

17. SIGNATURE OF CLERK

18. SIGNATURE OF JUDGE

19. SIGNATURE OF SHERIFF

20. SIGNATURE OF TOWNSHIP CLERK

21. SIGNATURE OF COUNTY CLERK

22. SIGNATURE OF STATE CLERK

23. SIGNATURE OF DEPARTMENT CLERK

24. SIGNATURE OF HEALTH COMMISSIONER

25. SIGNATURE OF DEPARTMENT SECRETARY

26. SIGNATURE OF DEPARTMENT CHIEF

27. SIGNATURE OF DEPARTMENT ASSISTANT

28. SIGNATURE OF DEPARTMENT CLERK

29. SIGNATURE OF DEPARTMENT ASSISTANT

30. SIGNATURE OF DEPARTMENT CLERK

31. SIGNATURE OF DEPARTMENT ASSISTANT

32. SIGNATURE OF DEPARTMENT CLERK

33. SIGNATURE OF DEPARTMENT ASSISTANT

34. SIGNATURE OF DEPARTMENT CLERK

35. SIGNATURE OF DEPARTMENT ASSISTANT

36. SIGNATURE OF DEPARTMENT CLERK

37. SIGNATURE OF DEPARTMENT ASSISTANT

INSTRUCTIONS

1. This certificate is to be filled out by the physician or other person who has attended the deceased person at the time of death. It should be filled out as soon as possible after death, and should be filed in the office of the health officer of the county or city in which the death occurred. It should be filled out in duplicate, and one copy should be filed in the office of the health officer of the county or city in which the death occurred, and the other copy should be filed in the office of the health officer of the State Department of Health. The certificate should be filled out in the following manner:

BUREAU V. S.

JAN 21 1938

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. The original copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00750

758 CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		STATE <u>Maryland</u> COUNTY <u>Harford</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>	
TOWN <u>Aberdeen</u>		LENGTH OF STAY (In this place) <u>Lifetime</u>		TOWN <u>Aberdeen</u>		STREET ADDRESS (If rural give location) <u>R.F.D.#1 Bush Chapel Rd.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R.F.D.#1 Bush Chapel Rd.</u>				STREET ADDRESS <u>R.F.D.#1 Bush Chapel Rd.</u>			
3. NAME OF DECEASED (Type or Print) (First) <u>Walter</u> (Middle) <u>Ray</u> (Last) <u>Harfield</u>				4. DATE OF DEATH (Month) <u>1</u> (Day) <u>24</u> (Year) <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>1-18-1908</u>	9. AGE last birthday <u>50</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Taxi Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Aberdeen Moving Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Harford Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Walter Lee Harfield</u>				14. MOTHER'S MAIDEN NAME <u>Susie Pitt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>219-03-5202</u>		17. INFORMANT & ADDRESS <u>Mrs. Maggie M. Harfield - Aberdeen, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
430.1 IMMEDIATE CAUSE (A) <u>Acute Coronary Thrombosis</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/30</u> , 19 <u>57</u> , to <u>1/24</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1/24</u> , 19 <u>58</u> , and that death occurred at <u>11:30P</u> M., from the causes and on the date stated above.							
SIGNATURE <u>George T. Stansbury</u>				ADDRESS (Street, city, town, state) <u>569 Revolution St., Havre de Grace, Md.</u>		DATE SIGNED <u>1/27/58</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-28-58</u>		NAME OF CEMETERY OR CREMATORY <u>Union Methodist Cem.</u>		LOCATION (City, town, or county) (State) <u>Aberdeen Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Al. Leach</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Atlee J. Bullock - Havre de Grace, Md.</u>		ADDRESS	
DATE <u>JAN 28 '58</u>							

INSTRUCTIONS

THIS FORM IS TO BE FILLED OUT BY THE PHYSICIAN OR OTHER PERSON HAVING KNOWLEDGE OF THE CAUSE OF DEATH. IT IS TO BE FILED IN THE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND. IT IS TO BE FILLED OUT IN THE FOLLOWING MANNER: 1. The name of the deceased, as given at birth, and the name by which he is known, and the name of the father. 2. The date of birth, and the place of birth. 3. The date of death, and the place of death. 4. The cause of death, as given by the physician, and the manner of death, as given by the coroner. 5. The name of the physician, and the name of the coroner. 6. The name of the hospital, and the name of the funeral home. 7. The name of the next of kin, and the name of the person who has the custody of the body. 8. The name of the person who has the custody of the body, and the name of the person who has the custody of the body. 9. The name of the person who has the custody of the body, and the name of the person who has the custody of the body. 10. The name of the person who has the custody of the body, and the name of the person who has the custody of the body.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

REG. NO. 100

1. NAME OF DECEASED

2. DATE OF BIRTH

3. PLACE OF BIRTH

4. DATE OF DEATH

5. PLACE OF DEATH

6. CAUSE OF DEATH

7. MANNER OF DEATH

8. NAME OF PHYSICIAN

9. NAME OF CORONER

10. NAME OF HOSPITAL

11. NAME OF FUNERAL HOME

12. NAME OF NEXT OF KIN

13. NAME OF PERSON WHO HAS CUSTODY OF BODY

14. NAME OF PERSON WHO HAS CUSTODY OF BODY

15. NAME OF PERSON WHO HAS CUSTODY OF BODY

16. NAME OF PERSON WHO HAS CUSTODY OF BODY

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49. NAME OF PERSON WHO HAS CUSTODY OF BODY

50. NAME OF PERSON WHO HAS CUSTODY OF BODY

BUREAU V. R.

JAN 28 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

735 CERTIFICATE OF DEATH

Reg. Dist. No.

00751

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harne-de-Grace</u>		c. LENGTH OF STAY IN 1b <u>24 hrs.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>24 Harne-de-Grace</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>			d. STREET ADDRESS <u>864 Erie ST. APT # 3</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Baby GIRL</u> First Middle Last <u>WARNER</u>			4. DATE OF DEATH Month <u>January</u> Day <u>6</u> Year <u>19 58</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/5/58</u>	9. AGE (In years last birthday) yrs. <u>24</u>	IF UNDER 1 YEAR Months <u>24</u> Days <u>24</u> Hours <u>24</u> Min. <u>24</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME <u>Chester Joseph Warner</u>			14. MOTHER'S MAIDEN NAME <u>Nancy Jane Powell</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Chester Warner 864 Erie ST. City Apt # 3</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.0</u> DUE TO <u>Atelectasis right lung</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>5 hour</u> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>5 hour</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <u>Jan 5</u> , 19 <u>58</u> , to <u>Jan 6</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Jan 6</u> , 19 <u>58</u> , and that death occurred at <u>5:00 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>B. J. Plunkett Jr.</u> M.D. <u>1-6-58</u>					
ACTUAL SIGNATURE <u>B. J. Plunkett Jr.</u> M.D. <u>1-6-58</u>					
PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>1-6-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>HARFORD MEMORIAL HOSPITAL</u>	22d. LOCATION (City, town, or county)	(State) <u>HARVE DE GRACE, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry R. Zully Administrator</u>			24a. REC'D BY REGISTRAR DATE <u>JAN 15 '58</u>	24b. REGISTRAR'S SIGNATURE <u>W. J. Leach</u>	

2071253XV2

JAN 15 1950

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

736

CERTIFICATE OF DEATH

00752

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAUCE DE GRACE</u>		c. LENGTH OF STAY IN 1b <u>17 DAYS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL Hospital</u>		d. STREET ADDRESS <u>WEST HALL</u>	
3. NAME OF DECEASED (Type or print) First <u>MOSES</u> Middle <u>JACOB</u> Last <u>WATTERS</u>		4. DATE OF DEATH Month <u>JANUARY</u> Day <u>28</u> Year <u>1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>COLORED</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 7-1872</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmlaborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Watters</u>		14. MOTHER'S MAIDEN NAME <u>Nettie Watters</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <u>219-34-4784</u>	
17. INFORMANT <u>William Watters</u> Address <u>Forest Hill Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input type="checkbox"/>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1/11</u> , 19 <u>58</u> , to <u>1/28</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1/28</u> , 19 <u>58</u> , and that death occurred at <u>12:40</u> M, from the causes and on the date stated above. A ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>George T. Stansbury</u> M.D. <u>569 Revolution St., Hauce de Grace, Md. 1/28/58</u> PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JAN 31/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mountain Methodist</u>		22d. LOCATION (City, town, or county) <u>Harford</u> (State) <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph T. Foster</u> ADDRESS <u>Bel Air Md</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 8 1958</u>	
24b. REGISTRAR'S SIGNATURE <u>W. L. Smith</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED JOHN W. SMITH		2. SEX Male		3. AGE 45	
4. DATE OF DEATH JAN 28 1958		5. TIME OF DEATH 10:30 AM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Myocardial Infarction		8. MANNER OF DEATH Natural		9. PLACE OF BIRTH Baltimore, Md.	
10. OCCUPATION Salesman		11. EDUCATION High School		12. RELIGION Roman Catholic	
13. MARITAL STATUS Married		14. NUMBER OF CHILDREN 3		15. PREVIOUS ILLNESS Hypertension	
16. SIGNATURE OF DECEASED (None)		17. SIGNATURE OF WITNESSES J. W. Smith, Jr. Mary Smith		18. SIGNATURE OF PHYSICIAN Dr. J. W. Smith	
19. SIGNATURE OF REGISTRAR J. W. Smith		20. SIGNATURE OF CLERK J. W. Smith		21. SIGNATURE OF CHURCH CLERK None	

BUREAU V. 2

JAN 30 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00753

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>02X-2</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>Glen Burnie</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>101 W Court Road</u>		d. STREET ADDRESS <u>606 Elizabeth Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Weir</u> Last <u>Weir</u>		4. DATE OF DEATH Month <u>January</u> Day <u>10</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 5, 1927</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electronic Technician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mid. Atlantic Jerrold Co</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>
13. FATHER'S NAME <u>Charles H. Weir, Sr</u>		14. MOTHER'S MAIDEN NAME <u>Clara E. Labatue</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>W.W. 11</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		17. INFORMANT <u>Mrs. Clara E. Weir, 606 Elizabeth Road</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Electrocution</u> <u>914.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Repairing TV antenna & touched line wire</u> 20c. TIME OF INJURY Month, Day, Year Hour <u>1</u> a.m. <u>1-10</u> p.m. <u>58</u> 20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>101 W Court Road Aberdeen Hartford MD</u> 20f. (City or town) (County) (State) <u>Aberdeen</u> <u>Hartford</u> <u>MD</u> 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, MD</u> DATE SIGNED <u>1-11-58</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>1-14-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Ritchie Hwy., Glen Burnie</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 S. Paul Street</u>		24a. REC'D BY REGISTRAR <u>JAN 14 '58</u>	24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. The burial copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

759 CERTIFICATE OF DEATH

00754

Reg. Dist. No. 180

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>BALT CO.</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Edgewood</u>		LENGTH OF STAY (in this place) <u>11 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore, Md.</u>		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Edgewood Road, Edgewood</u>				STREET ADDRESS (If rural give location) <u>1219 N. Charles St</u>			
3. NAME OF DECEASED (Type or Print) <u>EVANGELINE HENDRICKS WISE</u>				4. DATE OF DEATH <u>JAN 23 19 58</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>NOV 17, 1878</u>	9. AGE last birthday <u>79</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13. FATHER'S NAME <u>Charles A. Rew</u>				14. MOTHER'S MAIDEN NAME <u>Sally Bagwell ARKINGTON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>JOHNER. WISE Edgewood, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
5391 IMMEDIATE CAUSE (A) <u>G.I. BLEEDING</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 mo</u>	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>DILATION OF ESOPHAGUS, ETIOLOGY UNDETERMINED</u>						<u>7 years</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. (C) <u>HEART FAILURE, AURICULAR FIBRILLATION</u>						<u>4 mo</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept 1957</u> , to <u>JAN 23, 1958</u> , that I last saw the deceased alive on <u>NOV 57</u> , 19 <u>57</u> , and that death occurred at <u>5:35 P</u> , from the causes and on the date stated above.							
SIGNATURE <u>Joseph P. Bertino</u>		M.D. <u>Box 905, Edgewood, Md</u>		ADDRESS (Street, city, town, state) <u>Belle Haven, Accomac, Va.</u>		DATE SIGNED <u>1/23/58</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>JAN 26 1958</u>		NAME OF CEMETERY OR CREMATORY <u>Belle Haven</u>		LOCATION (City, town, or county) (State) <u>Belle Haven, Accomac, Va.</u>	
24. REC'D BY REGISTRAR <u>JAN 29 58</u>		REGISTRAR'S SIGNATURE <u>Alfred</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Howard P. Thomas</u>		ADDRESS <u>Abingdon, Md.</u>	

CERTIFICATE OF DEATH

File No. 100-100000

1. OF ALL RESIDENCES KNOWN TO DECEASED

MARYLAND

PLACE OF BIRTH

2. DATE OF BIRTH

1900

3. SEX

4. OCCUPATION

5. CAUSE OF DEATH

6. PLACE OF DEATH

7. DATE OF DEATH

8. TIME OF DEATH

9. SIGNATURE OF DECEASED

10. SIGNATURE OF WITNESSES

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF CLERK

14. SIGNATURE OF JURY

15. SIGNATURE OF JUDGE

16. SIGNATURE OF SHERIFF

17. SIGNATURE OF CLERK

18. SIGNATURE OF JURY

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255. SIGNATURE OF JUDGE

256. SIGNATURE OF SHERIFF

257. SIGNATURE OF CLERK

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CERTIFICATE OF DEATH

Reg. Dist. No. 40755

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockes</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockes</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <u>NADMI Cooper Zink</u>		4. DATE OF DEATH <u>Jan 27 1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 16 1890.67 5TH</u> yrs. Months Days Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>
13. FATHER'S NAME <u>John Edson Foist</u>		14. MOTHER'S MAIDEN NAME <u>Emma Cooper</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>315-03-2069B</u>	
17. INFORMANT <u>Jm P Zink Jr Same</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-RESP FAILURE</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CEREBROVASCULAR ACCIDENT</u> DUE TO (c) <u>HYPERTENSION & PREVIOUS CVA'S</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u> <u>10 DAYS</u> <u>20 YEARS.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>APR. 1950</u> , to <u>26 JAN 1958</u> , that I last saw the deceased alive on <u>26 JAN 58</u> , and that death occurred at <u>1:20 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. P. Sidwell</u>		ADDRESS (Street, city or town, state) <u>401 Franklin Baltimore</u>	
PHYSICIAN'S NAME (Type) <u>H. P. SIDWELL M.D.</u>		DATE SIGNED <u>27 Jan 58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Jan 30 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Danville Ridge</u>	22d. LOCATION (City, town, or county) (State) <u>Pikesville Baltimore Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Jenkins</u>		24a. REC'D BY REGISTRAR <u>Ann Co 4905 York Rd</u>	
24b. REGISTRAR'S SIGNATURE		24c. DATE <u>Jan 29 58</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE AVERA

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